

## DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



May 3, 2002

ALL-COUNTY LETTER NO. 02-34

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY WELFARE-TO-WORK  
COORDINATORS  
ALL COUNTY CIVIL RIGHTS COORDINATORS  
ALL COUNTY CHILD CARE COORDINATORS

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order or Settlement Agreement
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

SUBJECT: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS  
(CalWORKs) PROGRAM COUNTY POST ASSESSMENT POLICIES  
AND PROCEDURES REMEDY NOTICES OF ACTION

REFERENCE: ALL-COUNTY LETTER (ACL) 02-20  
ALL COUNTY LETTER (ACL) 02-03

**BACKGROUND**

The purpose of this All County Letter (ACL) is to transmit temporary Notices of Action (NOAs) for county use to inform participants of the result(s) of the county's review of their CalWORKs Welfare-to-Work (WTW) Activities Review Request Form (TEMP 2200). This letter is the final of three letters and is a follow-up to ACL Nos. 02-03 and 02-20. ACL No. 02-03 addressed county CalWORKs WTW post assessment policies and procedures, specifically those limiting referrals to WTW education or training activities, that are inconsistent with state law and regulations. ACL No. 02-20 provided instructions to counties on how to correct specific actions that harmed clients due to the implementation of the WTW post assessment policies detailed in ACL No. 02-03.

**CalWORKs WTW ACTIVITIES REVIEW REQUEST NOTICES OF ACTION (NOA)**

The following forms are enclosed for county use:

- CalWORKs WTW Activities Review Request Denial NOA (TEMP 2206)
- CalWORKs WTW Activities Review Request Approval NOA (TEMP 2207)
- CalWORKs WTW Activities Review Request Cash Aid Approval NOA (TEMP 2208)
- CalWORKs WTW Activities Third Party Assessment NOA (TEMP 2209)

- CalWORKs WTW Activities Review For Supportive Services Denial NOA (TEMP 2211)
- CalWORKs WTW Activities Review For Supportive Services Approval NOA (TEMP 2212)

The NOAs inform recipients of any remedies that are approved or denied as a result of the individual case review of their situation by county welfare department (CWD) staff. More than one remedial action may be appropriate. After reviewing and evaluating the information on the CalWORKs WTW Activities Review Request Form (TEMP 2200), that was submitted by the client, the CWD must determine whether the individual is, or is not, entitled to remedial benefits or actions as a result of the county's review. Before issuing any retroactive underpayment, counties must review the case to confirm that there are no existing overpayment(s). Retroactive benefits must be offset against any outstanding overpayments in accordance with MPP Section 44-531.3.

Page Six of ACL 02-20 specifies the timeframes counties must follow to process claims and to mail notifications of decision(s) to affected participants. Counties are required to use the attached NOAs, as appropriate, to approve or deny requests for benefits or remedies.

## **SUPPORTIVE SERVICES**

In addition to completing the appropriate sections of the CalWORKs WTW Activities Review Request Approval Form (TEMP 2207), if the claimant is eligible to receive supportive services, counties must provide specific information about the total amount due for retroactive child care, transportation, and ancillary expenses and how those amounts were calculated.

Counties must complete the CalWORKs WTW Activities Review Supportive Services Approval NOA (TEMP 2212), when granting approval of child care, transportation, and ancillary costs. Child care, transportation, and ancillary information must include the time period and the amount to be reimbursed on the CalWORKs WTW Activities Review Request Approval NOA (TEMP 2212). Counties must attach to the CalWORKs WTW Activities Review Request Approval NOA (TEMP 2212) calculations that indicate how the child care payment amount for each month was derived. Counties must use the TEMP NA 820a notice to document transportation costs.

Counties must complete the CalWORKs WTW Activities Review For Supportive Services Denial NOA (TEMP 2211) when denying child care, transportation and/or ancillary costs. Counties are required to provide the total amount of child care costs not being reimbursed, the time period to which those costs were claimed, and the

reason for denying those costs. Counties must also provide specific calculation information indicating how total amounts due for retroactive transportation and ancillary expenses were reached, if the amount that will be reimbursed is less than the amount claimed by the participant.

Counties must provide the name of a contact person, and his/her telephone number, on both the CalWORKs WTW Activities Review For Supportive Services Denial NOA (TEMP 2211) and the CalWORKs WTW Activities Review For Supportive Services Approval NOA (TEMP 2212) so the participant knows who to call if he/she has questions.

### **THIRD PARTY ASSESSMENT**

In addition to completing the appropriate sections of the CalWORKs WTW Activities Review Request Denial Form (TEMP 2206) or the CalWORKs WTW Activities Review Request Approval Form (TEMP 2207), if a person has noted on the CalWORKs WTW Activities Review Request Form (TEMP 2200) that they did not receive a third party assessment, counties must provide specific information regarding the approval or denial of the recipient's request for a third party assessment on the CalWORKs WTW Third Party Assessment NOA (TEMP 2209). The CalWORKs WTW Activities Third Party Assessment NOA (TEMP 2209) is also to be used to notify the recipient of the date, time, and place where the third party assessment will occur and the worker to contact if he/she has any questions about the process.

### **TRANSLATIONS**

If your office has internet access, you may obtain the notices from the Department's web page at <http://www.dss.cahwnet.gov>. To accommodate agencies without Internet access, copies can be obtained by contacting the Forms Management Unit (FMU). For camera-ready copies of English and Spanish notices, call the FMU at (916) 657-1907 or CALNET at 437-1907.

Your Forms Coordinator now receives all translations as soon as they become available, if your county is on the Language Translation Services (LTS) mailing list. All these notices are being translated into Russian, Chinese, and Vietnamese. These translations will follow shortly. Call LTS at (916) 654-1282 if your county does not receive the Russian and Asian translations. For languages that the State is not translating, if your county has a group that comprises five percent or more of the county population, the county must assure that a written translation (if a written language exists) of these notices is provided. Counties are reminded to follow the provisions of Division 21 for providing effective bilingual services.

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Although the enclosed notices are required and substitutes are **not** permitted, counties may reformat the notices to meet individual county requirements.

If you have any questions about the instructions in this letter or the use of the CalWORKs WTW Activities Review Request Denial NOA (TEMP 2206), the CalWORKs WTW Activities Review Request Approval NOA (TEMP 2207), the CalWORKs WTW Activities Review Request Cash Aid Approval (TEMP 2208), or the CalWORKs WTW Third Party Assessment NOA (TEMP 2209), please contact Ellen Horton, Employment Bureau, at (916) 651-6567.

If you have any questions regarding CalWORKs cash grant eligibility, please contact Eden Eulingborough, Eligibility Bureau, at (916) 653-4992. For questions related to transportation and ancillary NOAs, please contact your Work Support Services analyst at (916) 654-1424. For questions related to child care underpayments and overpayments, please contact your county child care consultant, Child Care Programs Bureau at (916) 657-2144.

Sincerely,

***Original Document Signed By  
Bruce Wagstaff on 5/3/02***

BRUCE WAGSTAFF  
Deputy Director  
Welfare to Work Division

Attachments

c: CWDA  
CSAC

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

Your benefits may not be changed if you ask for a hearing before this action takes place.

You asked that your CalWORKs welfare-to-work activity assignment be reviewed for the following reason(s):

- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_

Based on our review of your CalWORKs Welfare-To-Work Activities Review Request Form and the information that you provided, **your request has been denied. Here's why:**

- ☐ Your CalWORKs Welfare-to-Work Activities Review Request Form was received after July 1, 2002.
- ☐ You did not give us the additional information/documentation regarding \_\_\_\_\_  
\_\_\_\_\_ that we asked for on \_\_\_\_\_ (DATE).
- ☐ The county did not limit you to less than 18/24 months of vocational training, adult basic education, General Equivalency Diploma (GED), English-as-a Second Language (ESL), or other educational program.
- ☐ The county limited you to less than 18/24 months of vocational training, adult basic education, General Equivalency Diploma (GED), English-as-a Second Language (ESL), or other educational program, but did so based on your individual assessment and not as a matter of general policy.
- ☐ The county did not send you to an education or training program, but it was based on your individual assessment, and not a general policy requiring that you only get education if you were working part-time or if you already had a high school diploma or GED.
- ☐ The county did not make everyone attend work experience as their first activity after signing their welfare-to-work plan.

- ☐ Your third-party assessment shows that your welfare-to-work plan was correct.
- ☐ You were not sanctioned.
- ☐ You were sanctioned, but not because you disagreed with one or more of the situations listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ Your request has been forwarded to \_\_\_\_\_  
\_\_\_\_\_ County. That county will be contacting you on the decision on your claim.

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-710, 42-711, & 42-716.

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.**

**If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.**

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

**While You Wait for a Hearing Decision for:**

### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.**

**To Get Help:** You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

You asked that the county review your CalWORKs welfare-to-work activity assignment for the following reason(s):

☐ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Based on our review of your CalWORKs Welfare-To-Work Activities Review Request Form and the information that you provided, **the county has approved the following action(s) to fix problems with your welfare-work assignment:**

☐ You will receive an additional \_\_\_\_\_ months/weeks (circle one) of training time which will be added to your 18- or 24 month time limit.

☐ We will correct your welfare-to-work plan to include \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-710, 42-711, & 42-716.

☐ We have removed the sanction based on the problems you listed in your review form. We have sent a separate notice about the aid we owe you.

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Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

**While You Wait for a Hearing Decision for:**

### Welfare to Work:

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### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
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## OTHER INFORMATION

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☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

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# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone : \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

Your benefits may not be changed if you ask for a hearing before this action takes place.

\_\_\_\_\_

The county incorrectly applied CalWORKs welfare-to-work program activity rules. To correct the problem we have removed your sanction for the period of \_\_\_\_\_ through \_\_\_\_\_.

- ☐ You do not want to get back cash aid payments for these months. For that reason, the months will not count against your 60-month time limit.
- ☐ You want to receive back cash aid payments for the months you were sanctioned. Because you want this back aid, these months will count against your 60-month time limit.

Your back cash aid is figured on the next page.

- ☐ We will send a check soon.
- ☐ Your check is enclosed.
- ☐ \$ \_\_\_\_\_ of your back cash aid will be used to pay your existing overpayment balance. By law, we must use back aid to pay back overpayments.

If you get Food Stamps, we will count your back cash aid as a resource but not as income. It will not count as income or as a resource in the month received.

You may get another notice from Food Stamps.

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-700.

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**While You Wait for a Hearing Decision for:**

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☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **If you need more space, check here and add a page.**

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My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

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NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

## (Continued)

**Underpayment Amount Owed**  
**(For Underpayments Occurring on or after 1-1-98)**

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_

**Underpayment Month and Year:** \_\_\_\_\_

<b>(A) Net Countable Income</b>					
Total Business Income	\$				
Business Expenses					
a. 40% Standard OR	-				
b. Actual	-				
Net Earnings from Self Employment	=				
Total Disability-Based Unearned Income (Assistance Unit (AU) + Non Assistance Unit (Non-AU) Members)	\$				
\$225 Disregard	-				
Nonexempt Unearned Disability-Based Income OR	=				
Unused Amount of \$225 Disregard	=				
Total Earned Income	\$				
Net Earnings from Self-Employment (from above)	+				
<b>Subtotal</b>	=				
Unused Amount of \$225 Disregard	-				
<b>Subtotal</b>	=				
Earned Income Disregard 50%	-				
<b>Subtotal</b>	=				
Nonexempt Unearned Disability-Based Income (from above)	+				
Other Nonexempt Income (AU + Non-AU Members)	+				
<b>Net Countable Income</b>	=				
<b>(B) Correct Cash Aid Payment</b>					
Maximum Aid Payment (# persons) \$ Amount (AU + Non-AU Members)	( )	( )	( )	( )	( )
Special Needs (AU + Non-AU Members)	+				
Net Countable Income From Section A	-				
<b>Subtotal A</b>	=				
Maximum Aid Payment (MAP) (AU Only)	\$				
Special Needs (AU only)	+				
<b>Subtotal B</b>	=				
Correct Cash Aid Amount <b>(Lesser of Subtotal A or B)</b>	\$				
<b>(C) Child Support Penalty Adjustment</b>					
25% Child Support Penalty	-				
<b>Subtotal C</b>	=				
<b>(D) Adjustments</b>					
a. Additional 25% Child Support Penalty	-				
b. Overpayment	-				
c. Cal-Learn Penalty	-				
d. Cal-Learn Bonus	+				
Adjusted Cash Aid:	<b>Subtotal D</b>	=			
<b>(E) Underpayment</b>					
Correct Cash Aid Amount	\$				
Cash Aid Paid To You	-				
<b>Subtotal E</b>	=				
<b>Amount of Underpayment for Each Month</b>	=				

**Rules:** These rules apply; you may review them at your Welfare Office: MPP 44-340.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of Page 1 tells how.

**TOTAL UNDERPAYMENT (All Months)** \$ \_\_\_\_\_

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

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Based on our review of your CalWORKs Welfare-to-Work Activities Review Request Form and the information that you provided, the county is taking the following action(s):

**Your request for a third party assessment has been denied. Here is why:**

- ☐ County records show that you did not disagree with results of your assessment.
- ☐ County records show that you disagreed with the results of your assessment, but you and the county worked out the problem.

**Your request for a third party assessment has been approved. Here is why:**

- ☐ County records show that when you disagreed with the results of your assessment you were not sent to a third party assessment.
- ☐ Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-711.556.

**You are scheduled for a third party assessment on \_\_\_\_\_**

\_\_\_\_\_ at \_\_\_\_\_  
(DATE)

**o'clock at \_\_\_\_\_**  
(ADDRESS)

**This appointment is very important. If you cannot keep this appointment, call \_\_\_\_\_**  
(WELFARE-TO-WORK WORKER)

**at ( ) \_\_\_\_\_ to schedule another**  
(PHONE)  
**date. If we are not available, please leave a message and we will get back to you.**

- ☐ **You are approved for a third party assessment, and we will send you a notice at a later date to tell you the date, time, and place of your appointment.**

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.**

**If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.**

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

**While You Wait for a Hearing Decision for:**

### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.**

**To Get Help:** You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

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## SUPPORTIVE SERVICES

### CHILD CARE

☐ Your back child care costs from \_\_\_\_\_ through \_\_\_\_\_ have been denied because:

☐ Your child care costs were covered

☐ Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### TRANSPORTATION

For the period from \_\_\_\_\_ through \_\_\_\_\_ your welfare-to-work transportation payment you asked for is:

☐ Denied

☐ Less than you asked for (you will receive another notice to show you how the county figured this amount)

Here's why:

☐ You are already getting as much as the County can pay because:

☐ the maximum mileage rate is: \$ \_\_\_\_\_ per \_\_\_\_\_.

☐ Public transportation is available.

☐ County-provided transportation is available.

☐ You were not in an approved welfare-to-work activity.

☐ You needed to travel less than one mile each way to get to you approved welfare-to-work activity.

☐ The transportation you asked for is not needed to attend your approved welfare-to-work activity because: \_\_\_\_\_

\_\_\_\_\_

☐ Other \_\_\_\_\_

\_\_\_\_\_

## TRANSPORTATION CONTINUED: ANCILLARY

☐ The following items you asked for were not approved for payment:

Item	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____

Here's why:

☐ Payment for this item was not necessary because:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ You did not need \_\_\_\_\_ for your welfare-to-work activity because:

☐ You were not in an approved welfare-to-work activity

☐ Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have any questions about this call your worker: \_\_\_\_\_ at ( ) \_\_\_\_\_.

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-750.

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.**

**If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.**

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

**While You Wait for a Hearing Decision for:**

### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.**

**To Get Help:** You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

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Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

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## SUPPORTIVE SERVICES

### CHILD CARE

☐ Your back child care costs from \_\_\_\_\_ through \_\_\_\_\_ have been approved for the amount of \$ \_\_\_\_\_. The attached sheet shows how we computed your child care costs.

☐ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### TRANSPORTATION

☐ Your transportation costs from \_\_\_\_\_ through \_\_\_\_\_ have been approved for the amount of \$ \_\_\_\_\_. The attached sheet shows how we computed your transportation costs.

☐ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ANCILLARY

☐ As of \_\_\_\_\_ (DATE) the county has approved your request for payment for the following items needed for your approved welfare-to-work activity:

Item	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

### Your payment:

☐ A check(s) to cover back supportive services costs due to you will be sent soon.

☐ A check(s) is enclosed for back supportive services due to you.

☐ Other : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions about this form, call your worker:

\_\_\_\_\_ (WORKER'S NAME)

at (     ) \_\_\_\_\_ (PHONE)

**Medi-Cal:** This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-750.

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.**

**If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.**

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

**While You Wait for a Hearing Decision for:**

**Welfare to Work:**

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

**Cal-Learn:**

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.**

**To Get Help:** You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# NOTICE OF ACTION

COUNTY OF \_\_\_\_\_

STATE OF CALIFORNIA  
HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ADDRESSEE)

Questions? Ask your Worker.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells you how.

For the period of \_\_\_\_\_ until \_\_\_\_\_, the County has approved your transportation for participating in your allowable Welfare to Work activity.

- ☐ The most we can pay is \$ \_\_\_\_\_ for a total of \_\_\_\_\_ miles per \_\_\_\_\_.
- ☐ The County has approved \$ \_\_\_\_\_ per \_\_\_\_\_ based on public transportation rates.
- ☐ The County has approved bus passes or tickets for a total of \_\_\_\_\_ per \_\_\_\_\_.

The County will only pay for transportation while you were attending your allowable Welfare to Work activity:

\_\_\_\_\_  
Your transportation payment limit is figured on this notice.

Mileage for driving can be paid only if there was no public transportation available, or it cost the same or less than public transportation. Public transportation was available when it took a two hour or less round trip to get you from your home to your activity on time. You cannot count time it took you to go to and from your child's school or child care. If you drove your car even though public transportation was available, you will be paid at the public transportation rate or the mileage rate, whichever is lower.

Your transportation payments will be ☐ Advanced to you

☐ Paid back to you ☐ Paid to your transportation provider

☐ Other:

You can call your Welfare to Work worker if you have questions.

- ☐ public transportation ☐ your car's mileage

\_\_\_\_\_ rate  
X \_\_\_\_\_ per \_\_\_\_\_  
=\$ \_\_\_\_\_

\_\_\_\_\_ rate  
x \_\_\_\_\_ per \_\_\_\_\_  
x \_\_\_\_\_ miles  
=\$ \_\_\_\_\_

- ☐ parking  
\$ \_\_\_\_\_ ☐ month ☐ school term ☐ other
- ☐ total back payments due/month from \_\_\_\_\_ through \_\_\_\_\_

\$ 0 / month

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

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\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

\$ \_\_\_\_\_ / \_\_\_\_\_

☐ total amount for all periods \$ \_\_\_\_\_

☐ see attached page for calculation details

**Rules:** These rules apply. You may review them at your welfare office: MPP 42-750.112

## YOUR HEARING RIGHTS

- You have the right to ask for a hearing if you disagree with any County decision regarding your status (standing) in Cal-Learn/Welfare to Work, your activity, or your supportive services.
- Asking for a hearing will not affect your CalWORKs cash aid.
- You have only 90 days to ask for a hearing.
- The 90 days started the day after we gave or mailed you a notice.

## WHILE YOU WAIT FOR A HEARING DECISION

If you disagree with the County's decision about your Welfare to Work status or your activity:

- You do not have to participate.
- You can keep going to an unapproved self-initiated program, but we will not pay you any Welfare to Work supportive services or give you any other services.
- You can keep going or start going to an activity different from the one we referred you to, but we will not pay you any Welfare to Work supportive services or give you any other Welfare to Work services.
- You cannot keep going or start going to an activity different from the one we referred you to if the activity is open to Welfare to Work participants only.

If you disagree with the County's decision about your Cal-Learn status or your activity:

- You cannot come into the Cal-Learn program if we have told you we cannot serve you.
- Cal-Learn will pay only Cal-Learn supportive services for an approved Cal-Learn activity.

To get supportive services payments, you must go to the activity the County has asked you to go to.

If you disagree with the County's decision about your supportive services payments, and you attend your approved activity, the County will pay supportive services as follows:

- If we have told you your payments will be lowered, you will get the lower rate.
- If we have told you your payments will be made in a different form, you will be paid in the different form.
- If we have told you your payments will stop; you will not get any more payments, even if you go to your activity.
- If we have denied payments before the hearing, you will not get the requested payments.

If the amount of supportive services the County pays while you wait for a hearing decision is not enough, you can stop going to your activity.

You may get free legal help at your local legal aid office or welfare rights group, or from the CCWRO.

**Hearing File:** If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950).

## HOW TO ASK FOR A STATE HEARING

**The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:**

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

### HEARING REQUEST

I want a hearing because of an action by the Welfare Department of \_\_\_\_\_ County about my

(Check appropriate program box)

☐ Cal-Learn ☐ Welfare to Work

(Check appropriate action box)

☐ Status ☐ Activity ☐ Supportive Services

☐ Other (list) \_\_\_\_\_

**Here's why:**

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☐ Check here and add a page if you need more space.

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

Name \_\_\_\_\_

Address \_\_\_\_\_

I need an interpreter at no cost to me. My language or dialect is: \_\_\_\_\_

☐ I want a copy of this page sent to me.

My Name: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_

My Case Number: \_\_\_\_\_

My signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_